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Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Physical Medicine and Rehabilitation

Description of the service or services in dispute:

1 Magnetic Resonance Imaging (MRI) on Bilateral Lumbar Spine without Contrast

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

Patient is a xxxxx. On xxxxxx, he was seen. He stated he was stepping down from a truck, lost his footing, and fell flat on both feet with an impact that injured his back. Pain was rated at 8/10 to his lumbar spine. He described radiation of pain to his left lower extremity, with associated numbness and tingling in the left lower extremity. He denied loss of bowel or bladder control. On exam, he had decreased range of motion in the lumbar spine in all planes, and there are no obvious deformities on inspection. Deep tendon reflexes were normal, sensation normal, muscle strength testing was normal. Straight leg raise was negative bilaterally. X-rays were negative for fracture or dislocation. On 06/17/15, the patient returned to clinic. On exam, he was neurologically intact and straight leg raise was negative and he had normal gait. An MRI of the lumbar spine and sacrum were ordered at that time. On 09/15/15, the patient returned to clinic. On exam, he had full range of motion of his lower extremities, deep tendon reflexes, sensation, and muscle strength was normal, and straight leg raise was negative on the right and positive on the left. He had normal gait.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 07/17/15, a utilization review report for the requested MRI of the lumbar spine without contrast noted the request was non-certified. It was noted x-rays of the lumbar spine were negative for fracture dislocation, and Official Disability Guidelines Low Back Chapter for MRI was utilized as a reference source. It was noted there were no objective indications of neurological compromise, nor was there any indication in the submitted records as to what treatment the patient had had up until that point. Therefore, the request was non-certified. On 08/07/15, a utilization review report for the requested lumbar spine MRI without contrast noted the request was non-certified. Reference source was Official Disability Guidelines Low Back Chapter, and it was noted there were no objective indications of neurological compromise or any indication as to what treatment the patient had had up until that point, and therefore, medical necessity for the requested procedure cannot be established, and the request was non-certified.

The submitted records indicate the patient has remained neurologically intact, and has received conservative care in the form of physical therapy. Criteria would include uncomplicated low back pain, with suspicion of cancer, infection, or other red flags, or with radiculopathy after at least 1 month conservative care or sooner if severe or progressive neurological deficits are noted. For the records provided for this review, there is lack of documentation of a question that the patient had tumors or infection, or other red flags, and there is lack of documentation that the patient had severe or progressive neurological deficits to warrant this exam. Therefore, it is the opinion of this reviewer that the request for magnetic resonance imaging (MRI) lumbar spine bilaterally without contrast is not medically necessary and prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- [ ] ACOEM-America College of Occupational and Environmental Medicine um
- [ ] knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- [ ] DWC-Division of Workers Compensation Policies and
- [ ] Guidelines European Guidelines for Management of Chronic
- [ ] Low Back Pain Interqual Criteria
- [x] Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- [ ] standards Mercy Center Consensus Conference Guidelines
- [ ] Milliman Care Guidelines
- [x] ODG-Official Disability Guidelines and Treatment
- [ ] Guidelines Pressley Reed, the Medical Disability Advisor
- [ ] Texas Guidelines for Chiropractic Quality Assurance and Practice
- [ ] Parameters Texas TACADA Guidelines
- [ ] TMF Screening Criteria Manual
- [ ] Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- [ ] Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)